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August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW,
Room 445-G
Washington, D.C. 20201

RE: CMS-4203-NC; Request for information regarding various aspects of the Medicare Advantage program.

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to respond to your Request for Information (RFI) seeking feedback on how to strengthen Medicare Advantage (MA) in ways that align with the Vision for Medicare and the CMS strategic pillars. We appreciate CMS' goal to create more opportunities to engage with stakeholders on these important issues.

While the RFI touches on a variety of topics, our response is focused on addressing your questions about network adequacy requirements and telehealth in Part B of the RFI. In our response, we will discuss how CMS may incorporate health equity considerations into both areas.

ABOUT QUEST ANALYTICS

Quest Analytics is a network adequacy standards organization. We work with 90% of Medicare Advantage health plans and have a direct relationship with CMS to help it measure and monitor Medicare Advantage health plan provider network adequacy. We are committed to the development of evidence based fair and equitable network adequacy standards that ultimately lead to improved health outcomes for patients.

NETWORK ADEQUACY

In Part B, Question 6, you ask how could network adequacy requirements be updated to further support access to care?

In alignment with CMS' strategic pillar of advancing health equity, you may consider evolving your current network adequacy standards, which are designed to measure MA beneficiary access to various health care provider specialty types, to also measure MA beneficiary access to provider characteristic types that are essential to meeting the health equity needs of the MA population.

To accomplish this, you may consider (1) developing a list of provider characteristic types that are essential to meeting the health equity needs of the MA population and (2) developing a health equity needs type county type designation. CMS could use this framework to measure and monitor MA beneficiary access to provider characteristic types that vary based on the county health equity needs type designation.

PROVIDER CHARACTERISTIC TYPES

Provider characteristic types that are essential to meeting the needs of the MA population could include a provider language characteristic type and a provider proximity to public transit characteristic type using the following rationale. There are many more possible characteristic types that could be identified.

LANGUAGE EXAMPLE

Nationwide, 8% of Medicare beneficiaries have limited English proficiency (LEP).[i] Limited English proficiency is especially higher among those of Hispanic ethnicity, with nearly half of all Hispanic beneficiaries (49%) having LEP, compared to 4% of non-Hispanics.[ii] Limited English proficiency is also higher among beneficiaries of certain races. Specifically, 57% of Asian beneficiaries, 27% of Native Hawaiian and other Pacific Islander beneficiaries, and 11% of American Indian/Alaska Native beneficiaries have limited English proficiency, compared to 5% of white beneficiaries and 3% of black beneficiaries.[iii] Individuals seeking health care are most likely to seek care from providers who speak their language and when MA health plan members feel comfortable engaging with providers, they will be more likely to comply with providers' recommendations, which increases their likelihood of having better health outcomes.[iv] MA health plan provider networks should therefore include a sufficient amount of providers who speak the same languages as their health plan members.

TRANSPORTATION EXAMPLE

Transportation barriers are often cited as barriers to care for Medicare beneficiaries.[v] Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. These consequences lead to poorer management of chronic illness and are associated with poorer health outcomes.[vi] In addition, transportation issues are particularly salient for rural Medicare beneficiaries, who are more likely than their younger counterparts to have travel-limiting health conditions. Rural residents are less likely to stop driving in the face of a travel-limiting medical condition, likely because there are no other viable options.[vii] This can put individuals and populations at risk of poor outcomes. Routine access to primary care is essential for Medicare beneficiaries and addressing transportation barriers is one important step in doing so. MA health plan provider networks should therefore include a sufficient number of providers that are easily accessible by public transit (or another similar measure).

We recommend that CMS consult with national experts and others to develop a selection of provider characteristic types that are critical to meeting the health equity needs of MA beneficiaries.

HEALTH EQUITY NEEDS TYPE COUNTY DESIGNATION

We recommend that access to health equity provider characteristic types be assessed at the county level, with counties classified into county type designations based upon health equity-based parameters of individual counties. These parameters could be informed by existing health equity county type designations, which include the Social Vulnerability Index (SVI).

The model could be based on population health, which would take into account county population health outcomes and county population health factors. This includes weighting parameters into discrete dimensions, which involve social and economic factors, health behaviors, clinical care, and environmental factors.[viii]

Like with the development of the provider characteristic types, we recommend that CMS consult with national experts and others to develop the health equity needs type county designations.

TELEHEALTH

In Part B, question 5 you ask (1) How could CMS advance equitable access to telehealth in MA? and (2) What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access?

In 2020, you enacted a regulation that provided MA plans a 10% credit towards the percentage of MA beneficiaries that must reside within the time and distance driving metrics for providers in the following specialties: Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology, OB/GYN, Endocrinology, and Infectious Diseases.[ix]

You may consider revisiting this policy to take several additional parameters into consideration in order to advance equitable access to telehealth and address issues related to limited broadband access.

One parameter you may consider is adjusting the telehealth credit based on broadband availability in a county. If broadband is determined to be accessible and affordable in a county, you may consider offering MA health plans a credit that is greater than 10 percent. Conversely, if broadband availability is determined to not be accessible and affordable in a county, you may consider offering a credit that is less than 10 percent.

Another parameter you may consider is adding to the provider specialty types that health plans are permitted to take the credit for. California's Medicaid program, which is managed by the Department of Health Care Services (DHCS), is in the process of building off the telehealth credit regulation you enacted, by proposing a telehealth credit regulation of its own.[x] However, DHCS proposed to add the following provider specialty types to the list of provider specialty types you permit: Gastroenterology, Hematology, Oncology, Non-Specialty Mental Health Providers and Pulmonology.[xi] Like DHCS, you may wish to identify additional provider specialty types that are essential to meeting the health care needs of the MA population to include in this policy.

Quest Analytics sponsored research to investigate these other parameters to inform a comprehensive telehealth credit policy framework. If you are interested in learning more about this framework, please contact me using the contact information below.

CONCLUSION

Thank you for taking the time to consider our response to your RFI. If you have any questions or comments, please feel free to reach out to me at zach.snyder@questanalytics.com or (206) 427-3895.

Sincerely,

Zach Snyder
VP Government Relations
Quest Analytics

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[i] CMS, Understanding Communication and Language Needs of Medicare Beneficiaries, available online at: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf
[ii] Ibid
[iii] Ibid
[iv] Glenn Flores, "Language Barriers to Health Care in the United States," The New England Journal of Medicine, 355;3, July 20, 2006, available online at: http:// mighealth.net/eu/images/b/bb/Flores3.pdf.
[v] University of Minnesota Rural Health Research Center, Barriers to Health Care Access for Rural Medicare Beneficiaries: Recommendations from Rural Health Clinics, accessed online at: https://3pea7g1qp8f3t9ooe3z3npx1-wpengine.netdna-ssl.com/wp-content/uploads/2021/09/UMN-RHC-Access-to-Care-PB_1.20_508.pdf
[vi] Samina Syed, "Traveling Towards Disease: Transportation Barriers to Health Care Access," J Community Health, 38(5): 976–993, October 2013, available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/pdf/nihms646723.pdf
[vii] Henning-Smith, C., Evenson, A., Kozhimannil, K., & Moscovice, I. (2018). Geographic variation in transportation concerns and adaptations to travel-limiting health conditions in the United States. Journal of Transport and Health, 8, 137-145
[viii] See County Health Rankings Working Paper, Different Perspectives for Assigning Weights to Determinants of Health (2010), accessed online at: https://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf
[ix] See Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance (2020), pg. 11; 42 CFR 422.116 (5).
[x] DHCS, Annual Network Certification Telehealth Discussion, July 19, 2022.
[xi] Ibid